DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 1 3

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: October 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.250 et seq.

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 82,817.00
b. FFY 2002 $ 188,555.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A(2b)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same

10. SUBJECT OF AMENDMENT: Non-state Owned Psychiatric Hospital Payment Methods

. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Not required under 42 CFR 430.12(b)(2)(i)

12. SIGNATURE OF STATE AGENCY OFFICIAL: Wendy Warring

13. TYPED NAME: Wendy E. Warring

14. TITLE: Commissioner

15. DATE SUBMITTED: December 26, 2000

16. RETURN TO:
Bridget Landers
Coordinator for State Plan
Division of Medical Assistance
600 Washington Street
Boston, MA 02111

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 28, 2000

18. DATE APPROVED: JUN 06 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL: Dennis M. Maloney for Donald Preston

21. TYPED NAME: Ronald P. Preston

22. TITLE: Associate Regional Administrator, DMSO

23. REMARKS:

OFFICIAL

State Plan under Title XIX of the Social Security Act
Massachusetts Medical Assistance Program

Methods Used to Determine Rates of Payment for Non-State-Owned Psychiatric Hospital Services

I. General Description of Payment Methodology

The following sections describe the methods and standards utilized by the Division of Medical Assistance (Division) to establish rates of payment by contract for services rendered by Non-State-Owned Psychiatric Hospitals and Substance Abuse Treatment Hospitals to patients entitled to medical assistance under M.G.L. c. 118E, §1 *et seq.* The rates described herein are effective October 1, 2000. These rates of payment do not apply to Recipients who are enrolled in the Division's Behavioral Health Plan.

(1) The Division has established a comprehensive statewide inpatient *per diem* rate for all participating psychiatric hospitals covering both routine and ancillary services provided to inpatients. The Division derived the statewide inpatient *per diem* rate by generating a base period rate for the period RY1996 through RY1998 (up to May 1998). The base period rate was inflation-adjusted to RY1998 dollars and then updated by the appropriate Medicaid acute inpatient update factors (SPAD inflation factors) to generate the RY2001 rate.

(2) An all-inclusive Administrative Day *Per Diem* Rate (AD Rate) is established for psychiatric hospitals for each Administrative Day. The AD Rate is based on the Medicaid acute inpatient administrative day rate and is comprised of a base *per diem* payment and an ancillary add-on ratio. The base *per diem* payment is the median calendar year 2000 nursing home rate for all nursing home rate categories, as determined by the Division of Health Care Finance and Policy (DHCFP). This base rate is $124.47. The ancillary add-on is based on the ratio of ancillary charges to routine charges, calculated for Medicaid-only eligible patients on AD status, using MassHealth claims data for the period October 1, 1997 to September 30, 1998. This ratio is 0.3824. The resulting AD rate (base and ancillary) was then updated by inflation adjustments to derive the AD rate for RY2001.

(3) The Division has established a comprehensive inpatient *per diem* rate for all participating substance abuse treatment hospitals covering both routine and ancillary services provided to inpatients. The Division derived the inpatient *per diem* rate by generating a base period rate for the period RY1997 through RY1999 (up to May 1999). The base period rate was inflation-adjusted to RY1999 dollars and then updated by the appropriate Medicaid acute inpatient update factors (SPAD inflation factors) to generate the RY2001 rate.

II. Definitions

Administrative Day (AD). A day of inpatient hospitalization on which a Recipient's care needs can be met in a less-intensive setting than a Psychiatric Hospital, and on which the Recipient is clinically ready for discharge, but an appropriate institutional or non-institutional setting is not readily available.

Administrative Day *Per Diem* Rate (AD Rate). An all-inclusive daily rate of payment paid to Non-State-owned Psychiatric Hospitals for Administrative Days.

Behavioral Health Plan (BHP). A managed care program for the administration, coordination and delivery of mental health and substance abuse services to Recipients enrolled in the BHP.

Charge. The amount that is billed or charged by a hospital for each specific service within a revenue center.

Department of Mental Health (DMH). An agency of the Commonwealth of Massachusetts established under M.G.L. c. 19, §1 *et seq.*

Department of Public Health (DPH). An agency of the Commonwealth of Massachusetts established under M.G.L. c. 17, §1.

Diagnostic and Statistical Manual of Mental Disorders, 4th edition (*DSM-IV*). The manual compiled and published by the American Psychiatric Association as a source of information about, categorization of, and diagnostic criteria for recognized psychiatric disorders.

Division of Health Care Finance and Policy (DHCFP). An agency of the Commonwealth of Massachusetts, Executive Office of Health and Human Services established under M.G.L. c. 118G.

Division of Medical Assistance (Division). An agency of the Commonwealth of Massachusetts established under M.G.L. c. 118E.

HURM Manual. The Commonwealth of Massachusetts Hospital Uniform Reporting Manual promulgated by DHCFP under 114.1 CMR 4.00.

Inpatient Day. The standard unit of measure, according to the HURM Manual, to report care of patients admitted to a hospital including the day of admission, but not the day of discharge. If both occur on the same day, the day is considered a day of admission and counts as one inpatient day.

Inpatient *Per Diem* Rate. An all-inclusive daily rate of payment for any and all Inpatient Services provided to a Recipient by a Non-State-Owned Psychiatric Hospital or Substance Abuse Treatment Hospital.

Medicaid Program (Medicaid). The medical assistance benefit plans administered by the Division pursuant to M.G.L. c. 118E, §1 *et seq.* and 42 U.S.C. §1396 *et seq.* (Medicaid).

Non-Acute Hospital. A hospital that is defined and licensed under M.G.L. c. 111, s. 51, with less than a majority of medical surgical, pediatric, maternity and obstetric beds, or any psychiatric facility licensed under M.G.L. c. 19, § 29.

Psychiatric Hospital. Any psychiatric facility licensed under M.G.L. c. 19, § 29.

Rate Year (RY). The fiscal year beginning October 1 and ending September 30.

Recipient. A person determined by the Division to be eligible for medical assistance under the Medicaid Program.

Substance Abuse Treatment Hospital. A non-acute hospital with 85% or more of its beds licensed by the Massachusetts Department of Public Health as Alcoholism Treatment Service or Substance Abuse Treatment beds. The hospital must also treat a patient population of which 85% or more have a primary diagnosis of substance use disorder as based on the *DSM-IV*.

III. Payment Methodology

III.A. Non-State-Owned Psychiatric Hospitals

(1) Determination of Inpatient *Per Diem* Rate

The Inpatient *Per Diem* Rate is an all-inclusive daily rate paid for any and all inpatient care and services provided by a non-State-Owned Psychiatric Hospital to a Medicaid Recipient, with the exception of any and all Administrative Days (see Section III.B.). The Inpatient *Per Diem* Rate covers room and board, routine nursing services, ancillary services, psychological testing, assessments, overhead, and other services, as is the customary practice among similar providers.

(a) Data Sources.

(i) Base Period. The RY1998 Inpatient *Per Diem* Rate was calculated using payments and Inpatient Days reported on Medicaid Psychiatric hospital claims data during the period RY1996 through RY1998 (up to May 1998). These are the same claims data that were used in the calculation of rates for RY1999. The base period was specified as Medicaid payments made during this same period, RY1996 through May 1998 Claims data and bed-days for Medicaid recipients enrolled in the Division's Behavioral Health Program are not included.

(ii) Update Factor. The Base Period amounts are adjusted for inflation from the Base Period through RY2001 using a composite index called the SPAD inflation factor. This adjustment factor is a blend of HCFA market basket and the Massachusetts Consumer Price Index (CPI). The SPAD inflation factors used to update the base period are 1.90% for RY1999 , 1.43% for RY2000, and 2.00% for RY2001.

(iii) Efficiency Standard. Under the former Payment On Account (PAF) payment system, there were no incentives for efficiency since Medicaid paid a percentage

of non-State-owned Psychiatric Hospital charges, and these charges were deregulated under state law. A 95 percent adjustment factor to the base statewide rate is used as an incentive for efficiency. This is the same efficiency adjustment factor that has been used by Medicare in setting payment for its managed care enrollees under the adjusted average per capita cost (AAPCC) payment system.

(b) **Determination of RY2001 Inpatient *Per Diem* Rates.** The Division calculated the base period statewide rate by taking a weighted average of payments per day reported on claims data for all hospitals participating in the Medicaid Psychiatric Hospital program at any time during the period RY1996-05/1998. The weights were based on the proportion of bed-days each hospital provided under the Medicaid Psychiatric Hospital program during this same period. As an incentive for improved efficiency, the Division took 95 percent of the base period rate to yield the final proposed statewide *per diem* rate for RY1998. RY1998 figures were then updated for inflation using the SPAD inflation factors of 1.90% for RY1999, 1.43% for RY2000, and 2.00% for RY2001.

(2) Determination of Rate for Administrative Day Patients

A Non-State-owned Psychiatric Hospital will be paid for Administrative Days using an Administrative Day *Per Diem* Rate (AD Rate). The AD Rate is an all-inclusive daily rate paid for each Administrative Day. The AD Rate is based on the Medicaid acute inpatient hospital administrative day rate, and is comprised of a base *per diem* payment and ancillary add-on. The base *per diem* payment is the median calendar year 2000 nursing home rate for all nursing home rate categories, as determined by the Division of Health Care Finance and Policy (DHCFP). This base rate is $124.47. The ancillary add-on is based on the ratio of ancillary charges to routine charges, calculated for Medicaid-only eligible patients on AD status, using MassHealth claims data for the period October 1, 1997 to September 30, 1998. This ratio is 0.3824. The resulting AD rate (base and ancillary) was then updated for inflation using the update factors 3.16% for RY1996, 2.38% for RY1997, 2.14% for RY1998, 1.90% for RY1999, 1.43% for RY2000, and 2.00% for RY2001. The resulting AD rate for RY2001 is $175.51.

III.B Substance Abuse Treatment Hospitals

(1) Determination of Inpatient *Per Diem* Rate

The inpatient *per diem* rate is an all-inclusive daily rate paid for any and all inpatient care and services provided by a substance abuse treatment hospital to eligible Medicaid recipients. The *per diem* rate covers all treatment components such as room and board, routine nursing and physician services, medications, initial substance abuse and psychiatric assessments, individual, family and group inpatient therapy services, radiology, ancillary services, overhead, and other services as is the customary practice among similar providers. The inpatient *per diem* rate was calculated as follows:

(a) Data Sources

(i) **Base Period.** The base period *per diem* rate was calculated using payments and inpatient days reported on Medicaid substance abuse treatment hospital claims data during the period RY1997 through May 1999. Claims data and bed-days for Medicaid recipients enrolled in the Division's BHP are not included in these calculations.

(ii) **Update Factors.** The inflation update factor used to convert all monetary figures to RY1999 dollars, and to update RY1999 rates for future rate years, is the same factor used in the Medicaid Acute Inpatient Hospital Program, and the Psychiatric Inpatient Hospital Program pursuant to Section **III.A. (1) (a) (ii)**. This SPAD inflation factor is a regional update factor specifically calculated to reflect changes in the hospital industry in Massachusetts. This inflation estimate is calculated by the Division of Health Care Finance and Policy and is based on a blend of the HCFA PPS Hospital Market Basket and the Massachusetts Specific Consumer Price Index. The SPAD inflation factors used to update the base period are 2.14% for RY1998, 1.90% for RY1999, 1.43% for RY2000, and 2.00% for RY2001.

(b) Determination of RY2001 Inpatient *Per Diem* Rate. The Division calculated the inpatient *per diem* rate by taking an average of payments per day reported on claims data for the base period RY1997 through May 1999. All monetary figures were updated for inflation using the SPAD inflation factors of 2.14% for RY1998, 1.90% for RY1999, 1.43% for RY2000, and 2.00% for RY2001. The resulting inpatient per diem rate for RY2001 is $501.24.

IV. Determination of Federally Mandated Disproportionate Share Adjustments

The Medicaid program will assist hospitals that carry a disproportionate financial burden of caring for the uninsured and low income persons of the Commonwealth. In accordance with Title XIX rules and requirements, Medicaid will make an additional payment adjustment to hospitals which qualify for such an adjustment. Eligibility requirements for each type of disproportionate share adjustment and the methodology for calculating these adjustments are described in Sections V and VI below.

(1) To qualify for any type of disproportionate share payment adjustment, a hospital must have a Medicaid inpatient utilization rate (calculated by dividing Medicaid patient days by total patient days) of not less than 1%.

(2) The total of all disproportionate share payments awarded to a particular hospital under Section V below shall not exceed the costs incurred during the year of furnishing hospital services to individuals who either are eligible for Medicaid or have no health insurance or source of third party coverage, less payments by Medicaid and by uninsured patients.

V. Federally Mandated Disproportionate Share Adjustments

(1) Data Sources. The Division shall determine for each fiscal year a federally mandated Medicaid disproportionate share adjustment for all eligible hospitals, using the data and methodology described below. The prior year DHCFP-403 report is used to determine Medicaid days, total days, Medicaid inpatient net revenues, total inpatient net revenues, total inpatient charges and free care charge-offs. If said DHCFP-403 report is not available, the Division shall use the most recent available prior year DHCFP-403 report to estimate these variables.

(2) Determination of Eligibility Under the Medicaid Utilization Method. The Division shall calculate a threshold Medicaid inpatient utilization rate to be used as a standard for determining the eligibility of all Non-acute Hospitals for the federally mandated disproportionate share adjustment. The Division shall determine such threshold as follows:

(a) First, calculate the statewide weighted average Medicaid inpatient utilization rate by dividing the sum of Medicaid days for all Non-acute Hospitals in the state by the sum of total inpatient days for all Non-acute Hospitals in the state.

(b) Second, calculate the statewide weighted standard deviation for Medicaid inpatient utilization statistics.

(c) Third, add the statewide weighted standard deviation for Medicaid inpatient utilization to the statewide weighted average Medicaid inpatient utilization rate. The sum of these two numbers is the threshold Medicaid inpatient utilization rate.

(d) The Division shall then calculate each hospital's Medicaid inpatient utilization rate by dividing each hospital's Medicaid inpatient days by its total inpatient days. If this

hospital-specific Medicaid inpatient utilization rate equals or exceeds the threshold Medicaid inpatient utilization rate calculated pursuant to Section V (2)(c), then the hospital is eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method.

(3) Determination of Eligibility Under the Low-Income Utilization Rate Method. The Division shall then calculate each hospital's low-income utilization rate. The Division shall make such determination as follows:

(a) First, calculate the Medicaid and subsidy share of net revenues by dividing the sum of Medicaid net revenues and state and local government subsidies by the sum of total net revenues and state and local government subsidies.

(b) Second, calculate the free care percentage of total inpatient charges by dividing the inpatient share of audited free care charge-offs by total inpatient charges.

(c) Third, compute the low-income utilization rate by adding the Medicaid and subsidy share of net revenues calculated pursuant to Section V (3)(a) to the free care percentage of total inpatient charges calculated pursuant to Section V (3)(b). If the low-income utilization rate exceeds 25%, the hospital is eligible for the federally-mandated Medicaid disproportionate share adjustment under the low-income utilization rate method.

(4) Determination of Payment. The payment under the federally mandated disproportionate share adjustment is calculated as follows:

(a) For each hospital determined eligible for the federally mandated disproportionate share adjustment under the Medicaid utilization method established in Section V (2), the Division shall divide the hospital's Medicaid utilization rate calculated pursuant to Section V (2)(d) by the threshold Medicaid utilization rate calculated pursuant to Section V (2)(c). The ratio resulting from such division is the federally mandated disproportionate share ratio.

(b) For each hospital determined eligible for the federally mandated disproportionate share adjustment under the low-income utilization rate method, but not found to be eligible for the federally mandated Medicaid disproportionate share adjustment under the Medicaid utilization method, the Division shall set the hospital's federally mandated disproportionate share ratio equal to one.

(c) The Division shall then determine, for the group of all eligible hospitals, the sum of federally mandated disproportionate share ratios calculated pursuant to Section V (4)(a) and Section V (4)(b).

(d) The Division shall then calculate a minimum payment under the federally mandated disproportionate share adjustment by dividing the amount of funds allocated pursuant to Section V (5) for payments under the federally mandated disproportionate share adjustment by the sum of the federally mandated disproportionate share ratios calculated pursuant to Section V (4)(c).

(e) The Division shall then multiply the minimum payment under the federally mandated Medicaid disproportionate share adjustment by the federally mandated Medicaid disproportionate share ratio established for each hospital pursuant to Section V (4)(a) and (b). Subject to the limits herein, the product of such multiplication is the payment under the federally mandated disproportionate share adjustment.

(5) Allocation of Funds. The total amount of funds allocated for payment to Non-acute Hospitals under the federally mandated Medicaid disproportionate share adjustment requirement is one hundred fifty thousand dollars annually. These amounts is paid by the Division of Medical Assistance, and distributed among the eligible hospitals as determined pursuant to Section V (4)(e).

VI. Extraordinary Disproportionate Share Adjustment for Psychiatric Hospitals.

The Division shall determine an extraordinary disproportionate share adjustment for all eligible Psychiatric Hospitals, using the data and methodology described in Section VI.

(1) Data Sources.

The Division shall use the DHCFP-403 report for the fiscal year two years prior to the fiscal year of the calculation of the disproportionate share adjustment to determine the cost, free care, charge, patient day, and net revenue amounts. If said DHCFP-403 report is not available, the Division shall use the most recent available previous DHCFP-403 report to estimate these variables. If the specified data source is unavailable, then the Division shall determine and use the best alternative data source.

(2) Determination of Eligibility.

(a) In order to be eligible for the extraordinary disproportionate share payment adjustment, a Psychiatric Hospital must:

1. specialize in providing psychiatric/psychological care and treatment;
2. provide for special active treatment such as treatment of deafness, developmental disabilities, and the elderly;
3. accept all patients without regard to their ability to pay;
4. consist partly or wholly of locked wards;
5. meet requirements for the receipt of federal matching funds;
6. meet the low-income standard as set forth in Section VI (2)(b); and
7. meet the unreimbursed cost standard as set forth in Section VI (2)(c).

(b) Low-income standard.

1. For each Psychiatric Hospital, the Division shall calculate the hospital-specific low-income utilization rate as follows:

   a. The Division shall divide each hospital's net Medicaid revenue by its total gross patient service revenue.